Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Telephone: (608) 266-1340
Fax: (608) 267-0394
http://www.dwd.state.wi.us/wc/

MEDICAL TREATMENT STATEMENT

SUPPLIES AND MEDICATIONS

Complete this form before the prehearing conference (if one is scheduled) and update it before the formal hearing. Bring this form to both the conference and hearing.

NOTE: An itemized statement for each expense claimed must be attached to this form and provided to the Worker's Compensation Division and other parties to this case at least 15 days before the hearing, according to section 102.17(8) of the statutes.

Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m)].

WC Claim Number	Employee Name
Employee Social Security Number	Employer Name
Injury Date	Insurance Company Name

Names of Providers of Treatment, Medication, or Supplies	**Total Charges**	**Amount Paid By Applicant**	**Amount Paid By Other Insurance Carriers** ***(Give Carriers' Names)***	**Unpaid Balance**
TOTAL:				